Handbook for Providers of Podiatric Services

Chapter F-200
Policy and Procedures for Podiatric Services

Illinois Department of Public Aid

CHAPTER F-200

PODIATRIC SERVICES

TABLE OF CONTENTS

APPENDICES

FOREWORD

PURPOSE

This Handbook has been prepared for the information and guidance of podiatrists who provide services to participants in the Department's Medical Programs. Limited guidance is contained in this handbook for the provision of medical diagnostic and therapeutic services for the care and treatment of disorders of the feet. Additional guidance for such medical services, whether provided by podiatrists or by physicians, can be found in the Handbook for Physicians, Chapter A-200. This handbook states Department of Public Aid policy with sufficient instructions and guidelines to enable podiatrists to:

- know which services provided to eligible participants are covered;
- submit proper billings for services rendered; and
- make inquiries to the proper source when it is necessary to obtain clarification and interpretation of Department policy and coverage.

This handbook can be viewed on the Department's website at

http://www.state.il.us/dpa/handbooks.htm

This handbook provides information regarding specific policies and procedures relating to podiatric services.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The updates will be posted to the Department's website at

http://www.state.il.us/dpa/medical_programs.htm

Podiatrists will be held responsible for compliance with all policy and procedures contained herein.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Comprehensive Health Services at 217-782-5565.

CHAPTER F-200

PODIATRIC SERVICES

F-200 BASIC PROVISIONS

For consideration to be given by the Department for payment of podiatry services, such services must be provided by a podiatrist or physician enrolled for participation in the Department's Medical Programs. Services provided must be in full compliance with both the general provisions contained in Handbook for Providers of Medical Services, General Policy and Procedures (Chapter 100) and the policy and procedures contained in this handbook. If the services are provided by a physician, they must also be in full compliance with the policy and procedures contained in Chapter A-200 of the Handbook for Physicians. Exclusions and limitations are identified in specific topics contained herein.

F-201 PROVIDER PARTICIPATION

F-201.1 PARTICIPATION REQUIREMENTS

A provider who holds a valid Illinois (or state of practice) license to practice podiatric medicine is eligible to be considered for enrollment to participate in the Department's Medical Programs.

- Residents generally are excluded from participation as the cost of their services is included in the hospital's reimbursement costs. If, by terms of their contract with the hospital, they are permitted to and do bill private patients for their services, participation may be approved.
- Hospital based podiatrists who are salaried, with the cost of their services included in the hospital reimbursable costs, are not approved for participation. Participation may be approved for those podiatrists whose contractual arrangement with the hospital provides for them to make their own charges for professional services.
- Podiatrists holding non-teaching administrative or staff positions in medical schools or hospitals may be approved for participation in the provision of direct services if they maintain a private practice.
- Teaching podiatrists who provide direct services may be approved for participation provided that salaries paid by medical schools or hospitals do not include a component for treatment services.

The provider must be enrolled for the specific category of service for which charges are to be made, i.e. category 04 - Podiatry Services.

Procedure: The provider must complete and submit:

- Form DPA 2243 (Provider Enrollment/Application)
- Form DPA 1413 (Agreement for Participation)
- CMS 1513 (Disclosure of ownership and controlling interest)
- W9 (Request for Taxpayer Identification Number)

These forms may be obtained from the Provider Participation Unit. E-mail requests for enrollment forms should be addressed to:

PPU@mail.idpa.state.il.us

Providers may also call the unit at (217)782-0538 or mail a request to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

The forms must be completed (printed in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the provider requests a specific enrollment date and it is approved by the Department.

Participation approval is not transferable - When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation must be completed. Claims submitted by the new owner using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

F-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix F-4.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic F-201.4.

F-201.3 PARTICIPATION DENIAL

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten calendar days after this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

F-201.4 PROVIDER FILE MAINTENANCE

The information carried in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the Department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified. When possible, notification should be made in advance of a change.

Procedure: The provider is to line out the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify the Department of corrections or changes may cause an interruption in participation and payments.

Department Responsibility

When there is a change in a provider's enrollment status or a change is submitted by the provider, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to any payees listed if the address is different from the provider.

F-202 PODIATRIST REIMBURSEMENT

When billing for services or materials, the claim submitted for payment must include a diagnosis and the coding must reflect the actual services provided. Any payment received from a third-party payer, a program participant or other persons applicable to the provision of services must be reflected as a credit on any claim submitted to the Department bearing charges for those services or items. (Exception: Department co-payments are not to be reflected on the claim. Refer to Topic 114.1 for more information on patient cost-sharing.)

F-202.1 CHARGES

Charges billed to the Department must be the provider's usual and customary charge billed to the general public for the same service or item. Providers may only bill the Department after the service or item has been provided.

A provider may only charge for services he or she personally provides, or which were provided under his or her direct supervision in the provider's office by the provider's staff. Providers may not charge for services provided by another provider, even though one may be in the employ of the other.

Charges for services and items provided to participants enrolled in a Managed Care Organization (MCO) must be billed to the MCO according to the contractual agreement with the MCO.

Allowable Charges By Teaching Podiatrists

Teaching podiatrists who provide direct patient care may submit charges for the services provided, if the salary paid them by the school or hospital does not include a component for treatment services. Charges for concurrent care for the benefit of teaching are not reimbursable and are not to be submitted for payment.

For non-surgical patients being seen in a hospital or in other medical settings, charges are to be submitted only if the teaching podiatrist is personally responsible for all services provided and is personally involved by having direct contact with the patient. The patient's medical record must be documented to show these requirements have been met. All such entries must be signed and dated by the podiatrist seeking reimbursement.

When charges are submitted for a hospitalized patient, it is required that the teaching podiatrist review the patient's history, physical examination findings, admission diagnosis and personally perform any service considered necessary to confirm or revise the podiatric diagnosis. The patient's medical record progress notes are to be documented showing the requirements have been met. The written,

typed or printed statement is to be entered in the patient's record in a timely manner. The entry is to be signed and dated by the teaching podiatrist.

Charges are to be submitted only when the teaching podiatrist seeking reimbursement has been personally involved in the services being provided. This means presence in the room performing or supervising the major phases of the services with full and immediate responsibility for all actions performed as a part of the diagnosis and treatment. The patient's record must be documented to show these requirements have been met. All such entries must be signed and dated by the podiatrist seeking reimbursement.

F-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services which do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 100, Topic 112.3.

Providers billing electronically should take special note of the requirement that Form DPA 194-M-C, Billing Certification Form, must be signed and retained for a period of three years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form DPA 194-M-C can be found on the last page of each Remittance Advice which reports the disposition of any electronic claims. Refer to Chapter 100, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

F-202.3 CLAIM PREPARATION AND SUBMITTAL

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100, Topics 112.5 and 120.1. For specific instructions for preparing claims for Medicare covered services, refer to Appendix F-1b.

Form DPA 1443, Provider Invoice, is to be used to submit charges for all podiatry services provided other than Medicare covered services. A copy of Form DPA 1443 and detailed instructions for completion are included in Appendices F-1 and F-1a.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix F-1 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scannability/imaging evaluation. Please send sample claims with a request for evaluation to the following address.

Illinois Department of Public Aid
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

F-202.31 Claims Submittal

All routine paper claims are to be submitted in a pre-addressed mailing envelope provided by the Department for this purpose, Form DPA 1444 Provider Invoice Envelope. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim, use Form DPA 1414 Special Approval Envelope. A non-routine claim is:

- Any claim to which Form DPA 1411, Temporary MediPlan Card, is attached.
- Any claim to which any other document is attached (operative report, etc.). Attachments are not to be stapled to the invoice. Use of paper clips is suggested.

For electronic claims submittal, Refer to Topic F-202.2 above. Non-routine claims may not be electronically submitted.

Payment will not be considered when surgical procedures subject to the 6 month limitations are billed unless an operative report is attached. If the surgery was done in a hospital, the operative report must be a copy of the operative report on file in the hospital. All claims which have reports attached must be sent to the Department in the Special Approval Envelope, Form DPA 1414.

F-202.32 Required Coding - Role, Procedure and Diagnosis Codes

Role Codes

In order to collect data and make appropriate payment, the Department requires that the billing invoice be completed with identification of the podiatrist's role in the delivery of services for which the charges are made. Consequently, special attention must be given to the preparation of billing invoices to insure that all services included on an invoice are those services provided in the same role. The definition and codes for completing item 5 (Role) of the Form DPA 1443 are included in Appendix F-1.

Procedure Codes

All services for which charges are made are to be coded on Form DPA1443 with specific codes as described in the fee schedule as referenced in topic 202.5. No other procedure codes are acceptable.

Diagnosis Codes

In addition to the coding required which describes the specific procedure performed, all invoices require a primary diagnosis code as listed in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), or upon implementation, International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) . Podiatrists are encouraged to identify and code any secondary diagnosis, if appropriate.

F-202.4 PAYMENT

Payment made by the Department for allowable services provided to participants who are not eligible for Medicare Part B benefits will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department. Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the Department and General Appendix 8 for explanations of Remittance Advice detail provided to providers.

In some instances the Department will request that the podiatrist submit for review additional information on claims on which payment is pending. If the request is for x-rays, the films submitted must show the podiatrist's name, the patient's name, the date the film was taken, and designation of right or left foot. The films will be returned subsequent to their review.

For participants eligible for Medicare Part B benefits, payment may be made on the deductible and co-insurance amounts and for Medicaid covered services not covered by Medicare. If the Department's rate is lower than Medicare's rate, it may result in no payment being due. Refer to Chapter 100, Topic 120.1.

F-202.5 FEE SCHEDULES

The Department's maximum reimbursement rates for the allowable procedures are listed on the Department's website. The listing can be found at

http://www.state.il.us/dpa/html/medicaidreimbursement.htm

Paper copies of the listings can be obtained by sending a written request to:

Illinois Department of Public Aid
Bureau of Comprehensive Health Services
201 South Grand Avenue East
Springfield, IL 62763-0001

The maximum rates, quantity limitation and prior approval requirements for each item are also available electronically. The Department maintains a downloadable rate file suitable for use in updating a provider's computerized billing system. This file is located in the same area on the Department's website as the listings described above. A copy of this file can also be obtained by sending a blank 3.5 inch IBM PC compatible diskette, a written request and a self-addressed, prepaid diskette mailer to the address listed above.

The website listings and the downloadable rate file are updated annually. Providers will be advised of major changes via a written notice. Provider notices will not be mailed for minor updates such as error corrections or the addition of newly created HCPCS codes.

F-203 COVERED SERVICES

A covered service is a service for which payment can be made by the Department. Refer to Chapter 100, Topic 103, for a general list of covered services.

> Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

The services covered in the podiatry program are limited and include only essential services for which medical necessity is clearly established. The Department determines the medical necessity of the service on the basis of the information submitted by the podiatrist.

While the various procedure codes listed in the fee schedules are to be used to designate services provided or procedures performed, such listing does not necessarily assure payment. In addition, there are some services usually not covered which may be approved in individual case situations. If a podiatrist believes a service or procedure not usually covered is the most appropriate for a particular situation, a request for prior approval may be initiated. Refer to Section F-211 Prior Approval Requirements. Any question a podiatrist may have about coverage of a particular service is to be directed to the Department prior to provision of the service. See Chapter 100 for addresses and telephone numbers to be used when making an inquiry.

F-204 NON-COVERED SERVICES

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to Chapter 100, Topic 104, for a general list of non-covered services. Additionally, the following podiatry services are excluded from coverage and payment cannot be made for these services:

- Visits and services provided to participants eligible for Medicare benefits if the services are determined not medically necessary by Medicare.
- Services to transitional assistance program participants, except for children 17 years of age and under in the city of Chicago.
- Services provided to participants in long term care facilities by a podiatrist who derives direct or indirect profit from total or partial ownership of such facility.
- Preventive or reconstructive services.
- Screening for foot problems.
- Visits by more than one family member on the same day when definitive pathology is not present.
- Provider transportation costs.
- X-rays and laboratory work when not specifically required by the primary condition for which the participant is being treated.
- X-ray and laboratory procedures performed at a location other than the podiatrist's office.
- Surgical assistants or co-surgeons.
- Services which are available from other sources including but not limited to private and governmental agencies.
- Treatment of flat feet, weak feet, pronation, non-involved sprains and strains and minor skin conditions, including services directed toward the care or correction of these conditions.
- Any services billed in association with non-covered services, such as x-ray, laboratory, routine visits, etc.
- Services performed in the absence of localized illness, symptoms or injury involving the foot or toe.
- Repeat surgery performed because the original surgery was not successful.
- Post operative x-rays are covered only as follow-up services subsequent to selected types of surgery or injury. Charges are not to be submitted for more than one plate during the post-operative period (minimum of 30 days), and only when the surgery is one of the surgical procedures subject to the 6 month limitations, or is a follow-up service subsequent to a fracture of the tarsal or metatarsal. Refer to Topic F-224 for details.

F-205 RECORD REQUIREMENTS

The Department regards the maintenance of adequate records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to Chapter 100, Topic 110 for record requirements applicable to all providers. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the podiatrist rendering the services.

The record maintained by the podiatrist is to include the essential details of the patient's condition and of each service or material provided. Any services provided a patient by the podiatrist outside the podiatrist's office are to be documented in the medical record maintained in the podiatrist's office. All entries must include the date and must be legible. Records which are unsuitable because of illegibility or because they are written in a language other than English may result in sanctions if an audit is conducted.

For patients who are in a hospital or a long term care facility, the primary medical record indicating the patient's condition, treatment and services ordered and provided during the period of institutionalization may be maintained as a part of the facility chart; however, an abstract of the facility record, including diagnosis, treatment program, dates and times services were provided, is to be maintained by the podiatrist as an office record to show continuity of care.

The Department and its professional advisors regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are a key document for post payment audits.

X-rays maintained as a part of the medical record must show the patient's name and date the x-rays were taken. The right or left foot must be designated.

> In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

F.205.1 REQUIREMENTS FOR OFFICE VISITS

Medical Record Documentation Required for Initial Visit, New Patient - In addition to the symptoms and complaints, the following documentation is required.

- A limited past history
- Onset and course of present condition including previous episodes

- Examination findings pertinent to present condition(s)
- Diagnostic procedures such as laboratory and x-ray examinations--listing all diagnostic procedures ordered, and their results
- Provisional diagnostic or problem-oriented impression
- Treatment record--injections given (drug, amount, dosage, etc.); any other medical treatment given; surgical treatment given or recommended; medication dispensed or prescribed
- Recommendations for follow-up or subsequent treatment
- Other details and specifics as the condition may require.

Medical Record Documentation Required for Subsequent Visit, Established Patient - In addition to the symptoms and complaints (or changes therein), the following documentation is required.

- Updated history
- Onset, duration and course of condition
- Examination findings related to affected area
- Provisional diagnosis
- Treatment given or recommended
- Diagnostic procedures ordered and their results
- Medication dispensed or prescribed.

F-210 GENERAL LIMITATIONS AND CONSIDERATIONS ON COVERED SERVICES

Certain services are covered only when provided in accordance with the limitations and requirements described below.

F-210.1 ROUTINE FOOT CARE SERVICES

Routine services (trimming of nails, treatment of callouses, corns, and similar services) are not covered except when a participant is under active treatment for diabetes mellitus or has a systemic condition that has resulted in severe circulatory impairment or an area of desensitization in the legs or feet and routine type foot care is required. In such instances care may not be provided in less than 60 day intervals. For residents in long term care facilities the routine services are covered only when the participant's medical record corroborates one or both of these conditions.

The podiatrist's records are to contain medical information pertinent to the diagnosis or condition which qualifies the patient for routine care, including the attending physician's name and description of treatment being provided by that physician for the diagnosis.

F-210.2 SURGERY

Surgical services are covered only if there is no practical and economical alternative method of treatment for the participant's condition. Additionally, certain procedures are covered only if surgery has not been performed in the previous six months. Refer to the fee schedule as referenced in topic F-202.5 for procedures restricted by this limitation.

When multiple surgical procedures are performed, reimbursement will be made for no more than two procedures (See Topic F-211 second dot point for an exception). Payment for the primary (more expensive) surgical procedure will be made at the lesser of the provider's usual and customary fee or the Department's allowable amount, and the additional procedure will be paid at 50% of the provider's usual and customary fee or the Department's allowable amount. When an independent procedure is commonly done as an integral part of a total service, no allowance will be made for the independent procedure.

F-210.3 DIVISION OF SPECIALIZED CARE FOR CHILDREN (DSCC)

Federal regulations require that persons less than 21 years of age who have congenital or acquired crippling conditions or conditions leading to crippling, must be referred to the Division of Specialized Care for Children (DSCC) for evaluation.

A crippling condition in this context is a tissue or functional defect of bone, muscle and joint origin which is chronic, or if unattended, may lead to chronicity with subsequent disability and handicap. Persons in this age group with congenital or acquired systemic disease which may also involve the feet, or foot conditions which are associated with, or may lead to impairment of the musculo-skeletal system beyond the feet (knees, hips) and those who require specialized health providers for proper evaluation, treatment design and management are to be referred to DSCC.

Examples of conditions which require referral to DSCC include the following severe or complex orthopedic handicaps involving the foot:

- Congenital club feet
- Congenital metatarsum varus; adductus metatarsus primus varus; Hallux varus requiring surgical treatment
- Tarsal coalition (rigid flat or peroneal spastic flatfoot)
- Congenital pes planus
- Congenital cleft foot (lobster claw)
- Pes cavus, pes cavorvarus
- Toe walker (e.g., congenital short heel cord) congenital contracture of triceps (sural muscle)
- Symptomatic pes planovalgus
- Malignant tumors
- Other conditions, unusual or severe, which may be crippling or lead to crippling.

F-210.4 SPRAINS

Treatment of sprains is a covered service. The podiatrist must bill for either an office visit or any covered procedure utilized e.g., wrapping, casting or application of a compression dressing (Unna Boot), but not both.

F-211 PRIOR APPROVAL REQUIREMENTS

Prior to the provision of certain services, and/or dispensing of certain materials, approval must be obtained from the Department.

If charges are submitted for services which require prior approval and approval was not obtained, payment will not be made for services as billed. See Chapter 100, Topic 111, for a general discussion of prior approval provisions.

The Department will not give prior approval for an item or service if a less expensive item or service is considered appropriate to meet the patient's need.

Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service.

The approval to provide the service does not include approval of the amount to be paid unless the Department specifies an amount with the approval. The podiatrist and the participant will be advised by the Department of approval or denial of the request.

The following services may be provided only with prior approval of the Department:

- Orthomechanics
- Multiple surgery for bilateral bunion corrections with osteotomies of the first metatarsals
- Surgical procedures within the six-month period following previous surgery. Refer to the fee schedule as referenced in topic F-202.5 for procedures restricted by this limitation.
- Unlisted services

F-211.1 PRIOR APPROVAL REQUESTS

Prior approval requests must contain enough information for Department staff to make a well-informed decision on medical necessity, appropriateness and anticipated patient benefits of the item or service. When it is necessary to provide an item or service outside of routine business hours, refer to Chapter 100, Topic 111.

The single most common reason for denial of prior approval requests is lack of adequate information upon which to make an informed decision.

The exact information needed will vary depending on the service requested and the medical condition of the patient, but the process described below is designed to cover the general information that is needed for all requests.

Prior approval requests may be submitted to the Department by mail, fax, telephone or electronically via the REV system.

By Mail:

The provider is to complete form DPA 1409, Prior Approval Request, when requesting covered services. A completed Form DPA 314A, Request for Approval for Podiatry Services, is to be attached to the Form DPA 1409. A sample copy of form DPA 1409 and instructions for its completion are found in Appendices F-2 and F-2a. A sample copy of form DPA 314A is found in Appendix F-3. All forms must be signed in ink by the provider or his or her designee.

By FAX:

Prior approval may be requested by fax. Complete Form DPA 1409, following the procedures described above for mailed requests. The completed form and other associated documents can be faxed to the number shown below. Providers should review the documents before faxing to ensure that they will be legible upon receipt. Colored documents, including the pink Form DPA 1409, often do not fax clearly. The Department recommends that such documents be photocopied and that the copy be faxed.

The fax number for prior approval requests is 217-524-0099. This fax is available 24 hours a day. Requests faxed during non-business hours will be considered to have been received on the next normal business day.

By Telephone:

When prior approval is requested by telephone, the request will be data entered by staff at one of the following telephone numbers:

217-785-6239
217-524-0005
217-524-7354
217-524-7357

These numbers are available Monday through Friday, 8:30 AM to 5:00 PM, excepting holidays.

The caller must be prepared to give all the information requested on the DPA 1409.

Electronically:

Prior approval requests may be electronically submitted into the Department's prior approval system by the provider via any of the Department's approved Recipient Eligibility Verification (REV) vendors. For more information on the REV system, refer to Handbook for Providers of Medical Services, Chapter 100 General Policies and Procedures, Topic 131.2. For a listing of approved REV vendors, refer to <http://www.state.il.us/dpa/html/medical_rev.htm>.

If the provider is mailing or faxing the documentation in support of an electronically-submitted request, this information should be noted in the comments section of the electronic request. In addition, the mailed or faxed materials should clearly indicate that the prior approval request has been electronically submitted. Failure to make these notations will make it more difficult for the Department to match the documentation with the prior approval request and thus may delay a decision on the request.

The Department reserves the right to request proof of a valid physician order or other supporting documentation before approval is granted.

F-211.2 ORTHOMECHANICAL SERVICES

The provision of orthotics will be considered for approval only when it has been established that there is no practical and more economical alternative method of treatment for the participant's condition.

Refer to the Handbook for Providers of Medical Equipment and Supplies for an explanation of policy and procedures relating to orthotics.

F-211.3 SURGICAL PROCEDURES WITHIN SIX MONTH PERIOD

Reimbursement will not be made for certain surgical procedures performed within a six month period following previous surgery unless prior approval has been obtained. Refer to the fee schedule as referenced in topic F-202.5 for procedures restricted by this limitation.

F-211.4 UNLISTED SERVICES

Services which are not specifically identified in the fee schedule require prior approval. Information to be submitted must describe in detail the service to be provided and the history of past treatment provided. Additionally, the request for approval must show why the treatment plan or service is better than any other plan commonly used to deal with similar diagnoses or conditions.

If the service is an emergency service, post approval for the service may be requested. The request form submitted for post approval must show the reason for the emergency service and the type of service provided.

F-220 OFFICE SERVICES

Medical and surgical services which are required for the diagnosis and treatment of conditions of the feet, and are determined to be covered services, may be provided by a podiatrist, or by his office staff, in his office under his direct supervision. Office services are considered by the Department to be provided in the role of Attending Practitioner.

All office services for which charges are made must be documented in the participant's office medical record. When a procedure is performed at the time of an office visit, a charge may be made for both the visit and the procedure. Payment will be made for the more expensive service, but not both.

F-220.1 VISITS

Two types of office visits are recognized by the Department. Each visit for which a charge is made is to be correctly identified by the podiatrist by use of the designated procedure code. Claims are not to be submitted with any other office visit procedure code.

1) Initial Visit, New Patient - The first visit of a patient who has not been seen before by the podiatrist (or any other podiatrist in the same group or office). This type of visit includes a history, physical examination (of the lower extremities) to the extent necessary to arrive at a provisional diagnosis, and an evaluation in response to presenting complaints and symptoms. Treatment is initiated and medical advice and direction given.

   An initial visit is allowed only one time by a podiatrist for an individual patient. In partnership or group practices, it is allowed only one time collectively for all podiatrists in the group who eventually may see the participant.

2) Subsequent Visit, Established Patient - Any return visit of an established patient for examination and treatment of a condition determined to be a covered service, treatment of new complaints or symptoms, or re-evaluation of a previous condition and evaluation of the patient's response to continuing treatment or therapy.

F-220.2 REFERRAL (TRANSFERRED PATIENT)

A referral applies to services provided a patient who is sent by one medical practitioner to another for diagnosis and treatment. This is not a consultation; it is the transfer of a patient, the receiving practitioner most frequently being a specialist.

A patient acquired in such a manner is considered to be a transferred patient and the visit to that podiatrist classified as a visit of a new patient.

PROCEDURE: Procedure code 90015 is to be used when billing for visits of referred patients. While no written report of the examination and findings is required to be sent to the referring medical practitioner, the referring practitioner's name and number must be entered on Form DPA 1443, (Field 12 Referring Practitioner Name) (Field 13 Referring Practitioner Number) when the claim is submitted for payment.

F-221 PHARMACY ITEMS

Pharmacy items which are essential for the accepted medical treatment of a participant's presenting symptoms and diagnosis are covered items for which payment can be made by the Department, when they are prescribed or dispensed in accordance with the following requirements and limitations.

The participant's medical record in the podiatrist's office is to contain entries regarding all items which are prescribed or dispensed, and the participant's response to treatment.

F-221.1 Prescriptions

Coverage of prescription pharmacy items and over the counter drugs is limited to those produced by drug manufacturers who have signed drug rebate agreements. A listing of rebating manufacturers is distributed quarterly by the Department. Pharmacy items, both prescription and over-the-counter items, which are covered in the Medical Assistance Program may be prescribed or dispensed in accordance with the following policy and procedure.

When writing a prescription, the podiatrist shall:

- Use his own prescription form or the official form required by law for the prescription of controlled substances; and
- Enter on the form the following information at a minimum:
  - Participant's name,
  - Date,
  - Name of pharmacy item prescribed,
  - Form and strength or potency of drug (or size of non-drug item),
  - Quantity,
  - Directions for use,
  - Refill directions,
  - Legible signature in ink, and
  - Drug Enforcement Administration (DEA) Number, Social Security Number (for podiatrists who do not have a DEA Number), or State License Number.

Not more than two refills may be authorized. The podiatrist is to indicate on the prescription whether or not it may be refilled and, if so, specify once or twice as appropriate.

The completed prescription form is to be given to the participant to take to the pharmacy of his choice, or a podiatrist may telephone a pharmacy to prescribe provided a participant is permitted free choice of pharmacy.

The podiatrist must not charge for writing a prescription and must not write prescriptions for injectables which are given in the podiatrist's office.

F-221.2 Long Term Care Restricted Items

The Drug Program identifies pharmacy items which may not be prescribed for recipients living in a licensed long term care facility. Payment to the facility includes payment for the provision of such items.

To obtain information on drugs and pharmacy items, call (217) 782-5565 and ask to speak to a pharmacy consultant.

F-222 DIAGNOSTIC AND LABORATORY SERVICES

Only those laboratory tests and examinations which are essential for diagnosis and control and listed in the fee schedules are covered. Laboratory tests for the purpose of screening are not allowed.

The podiatrist may not charge for blood work by the "dipstick" method, unless a colorimetric instrument is used for evaluation of the results. Payment on charges made for 3 or more blood tests that can be performed on the same specimen as a part of a panel or profile tests, is made on the same basis as though automated equipment was used.

A central laboratory serving podiatrists in group practices is considered a podiatrist's office laboratory, except where the laboratory is a Medicare certified clinical laboratory.

The appropriate procedure code is to be used when billing for office laboratory tests. When laboratory tests only are done, an office visit charge may not be made.

Podiatrists providing laboratory services in an office setting must be in compliance with the Clinical Laboratory Improvements Amendment (CLIA) Act. Refer to the Handbook for Providers of Laboratory Services Section L-201.5 for detailed information about CLIA certification. To receive reimbursement for laboratory services a podiatrist must have a current CLIA certificate on file with the Department.

PROCEDURE: Charges for office laboratory tests are to be submitted on Form DPA 1443. The test is to be described and appropriately coded.

For necessary laboratory tests not done in the podiatrist's office, the podiatrist may make written referral to 1) the outpatient department of a participating hospital; 2) a pathologist in private practice; or 3) a Medicare certified clinical laboratory. When such a referral is made, the podiatrist must specify the tests ordered. The podiatrist must use discretion in ordering only those laboratory tests necessary and pertinent to the condition which he is treating.

When referral is made to a clinical laboratory, the podiatrist is to include his State Podiatric License Number and the patient’s diagnosis, presenting symptoms, or the condition which indicates a need for the specific tests ordered.

F-224 RADIOLOGY SERVICES

X-ray services are covered when necessitated by disease or injury, or when required to diagnose a specific condition of the foot. When films taken appear to be excessive in number or are inconsistent with the diagnosis or condition, payment will be disallowed. Routine x-rays for the purpose of screening are not covered services. Multiple views are to be taken on one film when feasible.

Charges may not be submitted for x-rays which are not readable.

A podiatrist may charge for x-ray examinations done in his office, by his own staff, using his equipment and supplies. Allowable procedures are listed in the fee schedules.

A central x-ray department serving podiatrists in a group practice is considered a part of the podiatrist's office.

When x-rays are the only service provided at the time of a visit, an office visit charge may not be made.

The podiatrist may make written referral to allow a participant to have x-ray examinations performed in the outpatient department of a participating hospital or by a radiologist in private practice. The podiatrist may not charge for such a referral. The provider of the x-ray services is to make charges directly to the Department. The charge for x-rays includes the provision of a written report to the referring podiatrist, which he is to file in the patient's medical record.

Post operative x-rays are covered only as follow-up services subsequent to selected types of surgery or injury. Charges are not to be submitted for more than one plate during the post-operative period (minimum of 30 days), and only when the surgery is one of the surgical procedures subject to the 6 month limitations, or is a follow-up service subsequent to a fracture of the tarsal or metatarsal.

F-230 SURGICAL SERVICES - OFFICE

When charges are made for essential surgical procedures done in the podiatrist's office, no additional charge may be made for the office visit. Customary surgical dressings, trays, or other materials used in conjunction with a surgical procedure are considered a part of the surgical procedure.

A charge is not to be submitted for post-operative office visits and treatment following surgery for a minimum of thirty days.

When a surgical procedure requires the administration of local anesthesia, no additional charges may be made for the anesthesia or for the administration of same, as both are considered an integral part of the surgical procedure.

F-250 HOSPITAL SERVICES

F-250.1 OUTPATIENT SERVICES

A podiatrist may refer patients for essential covered services such as laboratory tests, x-ray examinations, etc., which are provided by a hospital on an outpatient basis. No charge may be made by the podiatrist for such a referral.

F-250.2 EMERGENCY SERVICES

The words “emergency services” mean those services which are for a medical condition manifesting itself by acute symptoms of sufficient severity (including but not limited to severe pain) such that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Charges may be made by a podiatrist who personally attends a patient in the emergency room, providing the podiatrist is not salaried by the hospital or associated with a group with a financial contract to provide emergency room care. A charge may be made for the visit and the specific procedure performed. Payment will be made for the more expensive service, but not both.

F-250.3 OUTPATIENT DEPARTMENT SERVICES

When a podiatrist sees a patient in the outpatient department of a hospital, the visit is considered the same as an emergency room visit.

F-250.4 INPATIENT SERVICES

The podiatrist may charge for essential visits to hospitalized patients no more frequently than once daily. All visits and services for which charges are made must be documented in the patient's hospital record. If the podiatrist is salaried by the hospital, he cannot bill the Department under his own name and number.

F-250.5 UTILIZATION REVIEW

The medical need for hospital admission and the length of the hospitalization are monitored and controlled by:

A Professional Standard Review Organization (PSRO)
or
A Hospital Utilization Review Committee (HURC)

In the hospitals located in an area in which a PSRO is operational, utilization review of all inpatient services provided to the Department’s Medical Programs participants and applicants is the responsibility of the PSRO, even though some of the services provided are not covered services for which payment can be made by the Department.

Where a PSRO is not operational, the HURC controls hospitalization of all inpatient services provided to the Department's Medical Program participants.

Limitations are placed on length of stay according to diagnosis and specific need of the individual participant for hospital care.

The podiatrist will be notified by the representative of the appropriate authority when a determination has been made that continued inpatient hospitalization is not essential. Charges for medical services provided during an unauthorized period of hospitalization are not to be submitted for payment.

PROCEDURE: If a podiatrist questions a determination that continued hospitalization is non-essential, he must contact the PSRO representative or the Chairman of the HURC.

F-260 SURGICAL SERVICES - HOSPITAL

The charge made for an operative procedure includes presurgical visit and complete post-operative care for a minimum period of 30 days. Charges are not to be submitted for this follow-up care even though one surgeon performs the surgical procedure and another provides the follow-up care. Additionally, charges are to be submitted only by the primary surgeon even though two or more surgeons may be present during the surgery.

> PROCEDURE: The appropriate procedure codes for the specific surgical procedures are to be entered on Form DPA 1443.

Hospital surgical services are considered by the Department to be provided in the role of surgeon.

Concurrent Care

There is no provision for reimbursement for daily or periodic routine concurrent care, with or without a prior consultation. However, when the complexity of a patient's condition necessitates the specialized services of more than one practitioner (regardless of the type of practitioner), either concurrently or successively during a period of hospitalization, charges for such care may be allowed only for the period of time necessary to resolve the complexity or complication. Adequate explanation of such problems and justification for treatment must be provided.

> PROCEDURE: The appropriate procedure code is to be entered on Form DPA 1443 to report hospital visits and other services provided. A copy of the hospital discharge summary must be submitted with Form DPA 1443 in the pre-addressed mailing envelope, Form DPA 1414, Special Approval Envelope.

Charges for concurrent care for the benefit of teaching and/or supervision are not allowed.

F-270 HOME AND LONG TERM CARE FACILITY SERVICES

A podiatrist may provide services to a participant in his place of residence (private home or a long term care facility) when the participant is physically unable to go to the podiatrist's office. The services which may be provided are limited to treatment of acute infections and non-surgical procedures.

Charges may be made for a visit or for the procedure provided at the time of a visit in accordance with policy applicable to office services (see Topic F-220), and within the limitations and requirements specified in this topic.

When more than one patient in a private home or long term care facility needs, and is provided service at the time of a visit, the visit to all additional patients is considered to be coincidental visits.

All services provided by the podiatrist to patients in long term care facilities are to be documented by the podiatrist in the medical record which is maintained by the facility, and all orders given by the podiatrist, to be carried out by the facility staff, are to be signed by him. A rubber stamp of the podiatrist's signature is not considered adequate. See Topic F-205 for additional record requirements.

Routine, non-essential visits to patients in long term care facilities are not allowed and payment will not be made for such care. Such care includes, but is not limited to, ordinary foot hygiene, the cleansing of the foot, use of skin creams to maintain skin tone, and the normal trimming of nails and removal of calluses, corns, etc. Payment to the facility for care includes the provision of such services.

Screening services, preventive services, and routine or periodic examinations are not covered. Charges for such visits are not to be submitted. Refer to Topic F-210.1 for an explanation of circumstances under which routine foot care services are considered covered services.

For patients in a long term care facility it is expected that treatment be billed no more often than once in a two month period. If unusual circumstances necessitate more frequent care, the patient's record at the facility must be documented with an explanation of the special circumstances and of the care provided.